FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029660

Facility Name: Mayfield Care Center

Address: 5905 W. Washington Blvd. (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 261-7074 **Fax #** (773) 261-2116

IDPA ID Number: 363336671001

Date of Initial License for Current Owners: 01/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	38,064	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	57,096	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,012		4,455	23,467	8
9	SNF/PED					9
10	ICF	26,995	140	70	27,205	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,007	140	4,525	50,672	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,735

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	203,146	33,097	15,015	251,258		251,258		251,258			1
2	Food Purchase		266,373		266,373	(31,000)	235,373	(7)	235,365			2
3	Housekeeping	195,046	47,951		242,997		242,997	822	243,819			3
4	Laundry	75,725	11,000		86,725		86,725		86,725			4
5	Heat and Other Utilities			132,074	132,074		132,074	2,972	135,046			5
6	Maintenance	70,102	17,947	26,964	115,013		115,013	2,641	117,654			6
7	Other (specify):*							23	23			7
8	**TOTAL General Services**	544,019	376,368	174,053	1,094,440	(31,000)	1,063,440	6,451	1,069,890			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,878,215	85,650	210,933	2,174,798		2,174,798	(3,277)	2,171,521			10
10a	Therapy	107,844		14,249	122,093		122,093		122,093			10a
11	Activities	82,184	9,663	1,106	92,953		92,953		92,953			11
12	Social Services	43,152		2,436	45,588		45,588		45,588			12
13	Nurse Aide Training											13
14	Program Transportation			43	43		43		43			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,111,395	95,313	238,367	2,445,075		2,445,075	(3,277)	2,441,798			16
	C. General Administration											
17	Administrative	206,595		72,000	278,595		278,595	11,805	290,400			17
18	Directors Fees											18
19	Professional Services			283,852	283,852		283,852	(220,162)	63,690			19
20	Dues, Fees, Subscriptions & Promotions			46,860	46,860		46,860	(32,308)	14,552			20
21	Clerical & General Office Expenses	55,489	33,854	39,305	128,648		128,648	62,861	191,509			21
22	Employee Benefits & Payroll Taxes			529,273	529,273	31,000	560,273		560,273			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,526	3,526		3,526	699	4,225			24
25	Other Admin. Staff Transportation			1,129	1,129		1,129	83	1,212			25
26	Insurance-Prop.Liab.Malpractice			3,443	3,443		3,443	180,413	183,856			26
27	Other (specify):*							38,809	38,809			27
28	**TOTAL General Administration**	262,084	33,854	979,388	1,275,326	31,000	1,306,326	42,200	1,348,526			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,917,498	505,535	1,391,808	4,814,841		4,814,841	45,374	4,860,215			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mayfield Care Center #0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,884	29,884		29,884	217,287	247,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,194	4,194		4,194	384,830	389,024			32
33	Real Estate Taxes			239	239		239	74,083	74,322			33
34	Rent-Facility & Grounds			807,813	807,813		807,813	(807,814)	(1)			34
35	Rent-Equipment & Vehicles			7,080	7,080		7,080	(6,914)	166			35
36	Other (specify):*							26,289	26,289			36
37	**TOTAL Ownership**			849,210	849,210		849,210	(112,239)	736,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		193,869	160,770	354,639		354,639		354,639			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,644	85,644		85,644		85,644			42
43	Other (specify):*	123,521			123,521		123,521	(123,521)				43
44	**TOTAL Special Cost Centers**	123,521	193,869	246,414	563,804		563,804	(123,521)	440,283			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,041,019	699,404	2,487,432	6,227,855		6,227,855	(190,386)	6,037,469			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	70,304	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,591)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,405)	21		24
25	Fund Raising, Advertising and Promotional	(19,523)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(168,247)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (147,469)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42,917)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (42,917)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (190,386)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mayfield Care Center
ID# 0029660
Report Period Beginning: 01/01/04
Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Medical Expenses	$ (884)	10	1
2	Franchise Tax Expense	(800)	21	2
3	Bank Charges	(280)	21	3
4	Theft and Loss	(183)	21	4
5	PP Adjustment- Contract Nursing	(2,393)	10	5
6	Non - allowable Salary	(13,046)	21	6
7	ICLTC Cope	(2,831)	20	7
8	Marketing Salaries	(123,521)	43	8
9	Capitalized R & M	(4,713)	06	9
10	Misc. Income	(100)	21	10
11	Excess Auto Lease	(7,800)	35	11
12	Annual Report Fees - Bldg. Co.	(100)	20	12
13	Bank Charges - Bldg. Co.	(120)	21	13
14	Accounting Fees - Bldg. Co.	(8,500)	19	14
15	Miscelaneous - Bldg. Co.	(33)	21	15
16	Amortization - Bldg. Co.	(3,663)	31	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(168,247)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(7)											(7)	2
3	Housekeeping			822									822	3
4	Laundry													4
5	Heat and Other Utilities			1,324	1,648								2,972	5
6	Maintenance	(4,713)		6,059	1,295								2,641	6
7	Other (specify):*				23								23	7
8	**TOTAL General Services**	(4,720)		8,205	2,966								6,451	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,277)											(3,277)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(3,277)											(3,277)	16
	C. General Administration													
17	Administrative			63,327	626	(52,148)							11,805	17
18	Directors Fees													18
19	Professional Services	(8,500)	8,500	(220,692)	135	395							(220,162)	19
20	Fees, Subscriptions & Promotions	(33,045)	100	572	7	58							(32,308)	20
21	Clerical & General Office Expenses	(33,967)	117	96,357	236	118							62,861	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			699									699	24
25	Other Admin. Staff Transportation			83									83	25
26	Insurance-Prop.Liab.Malpractice		179,379	869	165								180,413	26
27	Other (specify):*			37,258		1,551							38,809	27
28	**TOTAL General Administration**	(75,512)	188,096	(21,527)	1,169	(50,026)							42,200	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,509)	188,096	(13,322)	4,135	(50,026)							45,374	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mayfield Care Center # 0029660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	70,304	135,346	10,306	1,206	125							217,287	30
31	Amortization of Pre-Op. & Org.	(3,663)	3,663											31
32	Interest		381,592	498	2,740								384,830	32
33	Real Estate Taxes		71,900		2,183								74,083	33
34	Rent-Facility & Grounds		(807,814)	11,986	(11,986)								(807,814)	34
35	Rent-Equipment & Vehicles	(7,080)		166									(6,914)	35
36	Other (specify):*		26,289										26,289	36
37	**TOTAL Ownership**	59,561	(189,024)	22,956	(5,857)	125							(112,239)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(123,521)											(123,521)	43
44	**TOTAL Special Cost Centers**	(123,521)											(123,521)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(147,469)	(928)	9,634	(1,722)	(49,901)							(190,386)	45

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rental Income	$ 807,814	Mayfield Building Limited	100.00%	$	$ (807,814)	1
2	V		32	Interest Income	1,939	Mayfield Building Limited	100.00%		(1,939)	2
3	V		21	Other Income	36	Mayfield Building Limited	100.00%		(36)	3
4	V		21	Bank Charges		Mayfield Building Limited	100.00%	120	120	4
5	V		32	Interest Expense		Mayfield Building Limited	100.00%	383,531	383,531	5
6	V		36	Mortgage Insurance		Mayfield Building Limited	100.00%	26,289	26,289	6
7	V		33	Real Estate Tax Expense		Mayfield Building Limited	100.00%	71,900	71,900	7
8	V		26	Insurance		Mayfield Building Limited	100.00%	179,379	179,379	8
9	V		20	Annual Report Fees		Mayfield Building Limited	100.00%	100	100	9
10	V		19	Accounting Fees		Mayfield Building Limited	100.00%	8,500	8,500	10
11	V		21	Miscellaneous		Mayfield Building Limited	100.00%	33	33	11
12	V		30	Depreciation Expense		Mayfield Building Limited	100.00%	135,346	135,346	12
13	V		31	Amortization		Mayfield Building Limited	100.00%	3,663	3,663	13
14	Total				$ 809,789			$ 808,861	$ * (928)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 822	$ 822	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,324	1,324	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	6,059	6,059	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	63,327	63,327	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	204	204	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	572	572	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	96,357	96,357	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	699	699	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	83	83	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	869	869	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	37,258	37,258	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	10,306	10,306	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	498	498	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,986	11,986	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	166	166	30
31	V	19	HOME OFFICE	220,896	MANAGCARE, INC.	100.00%		(220,896)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 220,896			$ 230,530	$ * 9,634	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,648	$ 1,648	15
16	V		6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,295	1,295	16
17	V		7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		23	23	17
18	V		17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		626	626	18
19	V		19	PROFESSIONAL FEES		MAZEL MANAGEMENT		135	135	19
20	V		20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		7	7	20
21	V		21	CLERICAL & GENERAL		MAZEL MANAGEMENT		236	236	21
22	V		26	INSURANCE		MAZEL MANAGEMENT		165	165	22
23	V		30	DEPRECIATION		MAZEL MANAGEMENT		1,206	1,206	23
24	V		32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,740	2,740	24
25	V		33	REAL ESTATE TAXES		MAZEL MANAGEMENT		2,183	2,183	25
26	V		34	RENT	11,986	MAZEL MANAGEMENT			(11,986)	26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 11,986			$ 10,264	$ * (1,722)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 19,852	$ 19,852	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	395	395	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	58	58	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	118	118	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,551	1,551	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	125	125	20
21	V								21
22	V	17	MANAGEMENT FEES	72,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(72,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 22,099	$ * (49,901)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Davis	Shareholder	Mgmt/Admin	69.32%	See Attached	13.55	22.58%	Salary	$ 34,852	17-1,17-7	1
2	Moshe Davis	Shareholder	Mgmt/Admin	0.50%	See Attached	16.00	26.67%	Salary	58,816	17-1	2
3	Moshe Wolf	Relative	Administrative	0	See Attached	13.08	23.36%	Alloc. Salary	16,839	17-7	3
4	Renita O'Connell	Shareholder	Administrative	1.34%	See Attached	9.81	23.36%	Alloc. Salary	20,393	17-7	4
5	Shoshana Braun	Shareholder	Nursing Clerical	0.50%	See Attached	10.00	25.00%	Salary	7,500	10-1	5
6	Chasida Davis	Relative	Clerical	0	See Attached	9.35	23.38%	Alloc. Salary	8,991	21-7	6
7	Renee Wolf	Relative	Clerical	0	See Attached	9.35	23.38%	Alloc. Salary	4,365	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 151,756		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	216,882	5	$ 3,519	$	50,672	$ 822	1
2	5	UTILITIES	PATIENT DAYS	216,882	5	5,668		50,672	1,324	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	216,882	5	25,935		50,672	6,059	3
4	10	NURSING SALARIES	PATIENT DAYS	216,882	5			50,672		4
5	17	ADMINISTRATIVE	PATIENT DAYS	216,882	5	271,046	271,046	50,672	63,327	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	216,882	5	875		50,672	204	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	216,882	5	2,447		50,672	572	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	216,882	5	412,419	353,888	50,672	96,357	8
9	24	SEMINARS	PATIENT DAYS	216,882	5	2,990		50,672	699	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	216,882	5	357		50,672	83	10
11	26	INSURANCE	PATIENT DAYS	216,882	5	3,719		50,672	869	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	216,882	5	159,470		50,672	37,258	12
13	30	DEPRECIATION	PATIENT DAYS	216,882	5	44,112		50,672	10,306	13
14	32	INTEREST EXPENSE	PATIENT DAYS	216,882	5	2,130		50,672	498	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	216,882	5	51,300		50,672	11,986	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	216,882	5	711		50,672	166	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 986,698	$ 624,934		$ 230,530	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	216,882	5	$ 7,053	$	50,672	$ 1,648	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	216,882	5	5,541		50,672	1,295	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	216,882	5	96		50,672	23	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	216,882	5	2,679		50,672	626	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	216,882	5	580		50,672	135	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	216,882	5	31		50,672	7	6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	216,882	5	1,012		50,672	236	7
8	26	INSURANCE	MNGCR. PATIENT DAYS	216,882	5	706		50,672	165	8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	216,882	5	5,162		50,672	1,206	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	216,882	5	11,726		50,672	2,740	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	216,882	5	9,342		50,672	2,183	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 43,928	$		$ 10,264	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	7	$ 87,900	$ 87,900	14	$ 19,852	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	7	1,750		14	395	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	7	257		14	58	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	7	521		14	118	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	7	6,869		14	1,551	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	7	552		14	125	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 97,849	$ 87,900		$ 22,099	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mortgage - GMAC		X	Mortgage			$	$ 5,242,294			$ 383,531	1
2	MB Financial Bank		X	Line Of Credit				535,000			4,193	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule										3,238	8
9	TOTAL Facility Related						$	$ 5,777,294			$ 390,962	9
	B. Non-Facility Related*											
10	Interest Income Building		X								(1,939)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,939)	14
15	TOTALS (line 9+line14)						$	$ 5,777,294			$ 389,023	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,289 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From Managcare		X				$	$			$ 498	8
9	Allocated From Mazel Mgmt.		X								2,740	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,238	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mayfield Care Center **#** 0029660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	45,313	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,335	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,022	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	59,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,322	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	42,788	8
	2000	41,017	9
	2001	41,833	10
	2002	44,331	11
	2003	58,152	12

Beginning Accrual adjusted by $313 for additional tax.

Alloc. From Mazel Mgmt. $2,183

Accrual= $58,152 x 1.02 = $59,300

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-08-419-002-0000	Long Term Property	$ 551.95	$ 551.95
2.	16-08-419-003-0000	Long Term Property	$ 12,940.30	$ 12,940.30
3.	16-08-419-004-0000	Long Term Property	$ 19,100.22	$ 19,100.22
4.	16-08-419-005-0000	Long Term Property	$ 13,242.39	$ 13,242.39
5.	16-08-419-006-0000	Long Term Property	$ 9,624.73	$ 9,624.73
6.	16-08-419-007-0000	Long Term Property	$ 2,692.60	$ 2,692.60
7.	See Attached	Allocation From Managcare/Mazel	$ 40,849.28	$ 2,188.08
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 99,001.47	$ 60,340.27

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mayfield Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029660

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 168,991	1
2					2
3	TOTALS			$ 168,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	11,950		20	-		11,898	9
10	Various			1986	24,199		20	1,273	1,273	23,449	10
11	Various			1987	12,137		20	392	392	6,889	11
12	Various			1988	38,957		20	1,258	(1,258)	20,844	12
13	Various			1989	57,789		20	2,890	2,890	44,920	13
14	Various			1990	40,078		20	1,391	1,391	27,112	14
15	Various			1991	34,073		20	1,704	1,704	22,578	15
16	Various			1992	1,200		20	60	60	770	16
17	Various			1993	6,071		20	304	304	3,454	17
18	Various			1994	24,281		20	1,214	1,214	12,416	18
19	Various			1995	1,467		20	73	73	690	19
20	Various			1996	64,140		20	3,207	3,207	27,394	20
21	Various			1997	15,923		20	796	796	6,015	21
22	Various			1998	966,314		20	48,318	48,318	298,033	22
23	Various			1999	137,374		20	6,868	6,868	38,784	23
24	Various			2000	43,701		20	3,013	3,013	14,175	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,595,648	135,346		79,782	(55,564)	272,714	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		62,025	2,795		2,681	(114)	46,696	68
69	Financial Statement Depreciation			29,884			(29,884)		69
70	TOTAL (lines 4 thru 69)		$ 3,137,327	$ 168,025		$ 155,224	$ (15,317)	$ 878,831	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,137,327	$ 168,025		$ 155,224	$ (12,801)	$ 878,831	1
2	Fire Dampers	2001	4,723		20	472	472	1,771	2
3	Kitchen Fan	2001	2,000		20	100	100	400	3
4	Carpet	2001	1,049		20	52	52	174	4
5	Elevator Motor	2001	1,800		20	90	90	278	5
6	New Ceiling & Lighting	2002	9,712		20	971	971	2,671	6
7	Compressor,Fan Blade & Motor	2002	3,341		20	334	334	807	7
8	Roof	2002	1,216		20	122	122	314	8
9	Elevator Piston	2003	837		20	42	42	49	9
10	Security Tv	2003	982		20	140	140	175	10
11	Elevator Repair	2003	1,300		20	65	65	114	11
12	Water Heater	2004	9,826		20	751	751	751	12
13	Coil Type Heater	2004	3,027		20	555	555	555	13
14	Storage Tanks	2004	1,877		20	250	250	250	14
15	Elevator	2004	10,150		20	296	296	296	15
16	Elevator	2004	2,500		20	31	31	31	16
17	Elevator Repair	2004	940		20	27	27	27	17
18	Adjusted Elevator Door	2004	680		20	26	26	26	18
19	Service On Video Monitoring Syst.	2004	588		20	7	7	7	19
20	Repair Walk-In Cooler	2004	928		20	8	8	8	20
21	Install New Smoke Detector	2004	595		20	20	20	20	21
22	Service On Video Monitoring Syst.	2004	982		20	49	49	49	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,196,380	$ 168,025		$ 159,632	$ (8,393)	$ 887,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156		1999		$ 1,595,648	$ 135,346		$ 79,782	$ (55,564)	$ 272,714	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,595,648	$ 135,346		$ 79,782	$ (55,564)	$ 272,714	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc. From Mazel Management		1985		$ 24,104	$ 969	20	$ 803	$ (166)	$ 15,467	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation - Managcare			1997	2,810	125	20	281	156	2,084	10
11	Allocation - Managcare			1993	220	-	20	11	11	127	11
12	Allocation - Managcare			1988	344	11	20	17	(6)	279	12
13	Allocation - Managcare			1986	26,068	1,331	20	1,194	(137)	24,081	13
14											14
15	Allocation - Mazel Management			2001	506	13	20	25	12	88	15
16	Allocation - Mazel Management			2000	256	7	20	13	6	54	16
17	Allocation - Mazel Management			1998	902	31	20	45	14	302	17
18	Allocation - Mazel Management			1997	841	22	20	42	20	308	18
19	Allocation - Mazel Management			1996	573	6	20	29	23	246	19
20	Allocation - Mazel Management			1995	130	3	20	6	3	62	20
21	Allocation - Mazel Management			1994	512	9	20	26	17	242	21
22	Allocation - Mazel Management			1993	302	9	20	15	6	173	22
23	Allocation - Mazel Management			1991	227	7	20	11	4	144	23
24	Allocation - Mazel Management			1990	352	7	20	18	11	253	24
25	Allocation - Mazel Management			1989	220	5	20	9	4	144	25
26	Allocation - Mazel Management			1987	500	10	20	-	(10)	500	26
27	Allocation - Mazel Management			1986	2,020	105	20	86	(19)	1,885	27
28	Allocation - Mazel Management			1985	141	-	20	-		141	28
29											29
30	Allocation - Intercare			2001	997	125	20	50	(75)	116	30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 62,025	$ 2,795		$ 2,681	$ (126)	$ 46,696	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 828,315	$ 965	$ 79,616	$ 78,651	10	$ 525,521	71
72	Current Year Purchases	7,909	243	258	15	10	258	72
73	Fully Depreciated Assets	139,487				10	139,436	73
74								74
75	TOTALS	$ 975,711	$ 1,208	$ 79,874	$ 78,666		$ 665,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. Managcare		$ 46,592	$ 7,634	$ 7,665	$ 31	5	$ 13,432	76
77										77
78										78
79										79
80	TOTALS			$ 46,592	$ 7,634	$ 7,665	$ 31		$ 13,432	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,387,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 176,867	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 247,171	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 70,304	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,566,251	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Alloc. From Managcare		$	$ 166	17
18					18
19					19
20					20
21	TOTAL		$	$ 166	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 68,227	$		$ 68,227	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			42,269			42,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			46,966			46,966	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				105,449		105,449	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					32,955		32,955	12
13	Other (specify): See Supplemental					3,308	55,465		58,773	13
14	TOTAL			$		$ 160,770	$ 193,869		$ 354,639	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center **#** 0029660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,001	$ 45,727	1
2	Cash-Patient Deposits	3,001	3,001	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,192,546	1,192,546	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,560	186,716	6
7	Other Prepaid Expenses	8,990	8,990	7
8	Accounts Receivable (owners or related parties)	216,286	216,286	8
9	Other(specify): See Attached Schedule	37,768	139,844	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,529,152	$ 1,793,110	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,991	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	78,181	1,193,205	15
16	Equipment, at Historical Cost	75,340	1,118,852	16
17	Accumulated Depreciation (book methods)	(93,531)	(1,618,434)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	65,470	1,359,934	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 125,460	$ 3,923,196	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,654,612	$ 5,716,306	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 485,821	$ 485,820	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,925	161,925	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,625	6,625	31
32	Accrued Real Estate Taxes(Sch.IX-B)		59,300	32
33	Accrued Interest Payable	1,170	1,170	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 655,541	$ 714,840	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	535,000	535,000	39
40	Mortgage Payable		5,242,294	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 535,000	$ 5,777,294	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,190,541	$ 6,492,134	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 464,071	$ (775,828)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,654,612	$ 5,716,306	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,047,643	1
2	Discounts and Allowances for all Levels	(418,149)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,629,494	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	342,419	6
7	Oxygen	2,628	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 345,047	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,051	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,000	19
20	Radiology and X-Ray	1,175	20
21	Other Medical Services	63,232	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,458	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,139	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,139	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,348	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,348	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,138,486	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,094,440	31
32	Health Care	2,445,075	32
33	General Administration	1,275,326	33
	B. Capital Expense		
34	Ownership	849,210	34
	C. Ancillary Expense		
35	Special Cost Centers	478,160	35
36	Provider Participation Fee	85,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,227,855	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,369)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,369)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 553,408	1	
2	Restatements (describe):		2	
3	**Restatement**	32	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 553,440	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(89,369)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (89,369)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 464,071	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,160	1,200	$ 32,357	$ 26.96	1
2	Assistant Director of Nursing	1,136	1,256	33,119	26.37	2
3	Registered Nurses	10,428	10,804	321,448	29.75	3
4	Licensed Practical Nurses	27,750	30,020	568,422	18.93	4
5	Nurse Aides & Orderlies	87,808	95,028	876,719	9.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,958	7,949	107,844	13.57	8
9	Activity Director	1,984	2,160	26,157	12.11	9
10	Activity Assistants	6,125	6,730	56,027	8.32	10
11	Social Service Workers	3,705	4,225	43,152	10.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,579	22,423	203,146	9.06	15
16	Dishwashers					16
17	Maintenance Workers	8,823	9,328	70,102	7.52	17
18	Housekeepers	21,685	23,544	195,046	8.28	18
19	Laundry	9,252	9,955	75,725	7.61	19
20	Administrator	1,992	2,200	89,448	40.66	20
21	Assistant Administrator	1,970	2,162	43,331	20.04	21
22	Other Administrative	1,766	1,766	73,816	41.80	22
23	Office Manager					23
24	Clerical	4,654	5,403	55,489	10.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,715	4,252	46,150	10.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,312	3,559	123,521	34.71	33
34	TOTAL (lines 1 - 33)	222,802	243,964	$ 3,041,019 *	$ 12.47	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	350	$ 15,015	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	22	2,306	10-03	38
39	Pharmacist Consultant	Monthly	4,980	10-03	39
40	Physical Therapy Consultant	28	2,594	10a-03	40
41	Occupational Therapy Consultant	32	2,421	10a-03	41
42	Respiratory Therapy Consultant	202	7,272	10a-03	42
43	Speech Therapy Consultant	20	1,962	10a-03	43
44	Activity Consultant	20	1,106	11-03	44
45	Social Service Consultant	44	2,436	12-03	45
46	Other(specify)				46
47	Quality Assurance Consultant	Monthly	1,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	718	$ 54,820		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	396	$ 11,825	10-03	50
51	Licensed Practical Nurses	5,911	186,694	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	6,307	$ 198,519		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joshua Weinstein	Administrator	0	$ 89,448
Patricia Holly	Asst. Admin.	0	43,331
Yosef Davis	Admin. Conslt.	69.32%	15,000
Moshe Davis	Admin. Conslt.	0.25%	58,816
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 206,595

B. Administrative - Other

Description	Amount
Management Fees - Intercare	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Econocare	Purchasing Consultant	$ 2,700
Kipp Computer Solutions	Computer Services	8,530
Myers, Miller & Krauskopf	Legal	5,901
Proclaim America	Legal	27
Managcare	Bookkeeping	220,896
American Data	Computer Services	4,902
Frost, Ruttenberg & Rothblatt	Accounting	34,585
FRS Healthcare	Management Conslt.	3,000
Personnel Planners	Unemployment Consult.	3,311
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 283,852

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,308
Unemployment Compensation Insurance	76,411
FICA Taxes	222,790
Employee Health Insurance	139,420
Employee Meals	31,000
Illinois Municipal Retirement Fund (IMRF)*	
City Taxes	5,632
Employee Pension/Union	25,942
Employee Pension/Employer	2,300
Employee Disability Insurance	2,986
Employee Benefits	3,424
Holiday Expense	1,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 560,273

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,104
Health Care Worker Background Check	
(Indicate # of checks performed 48)	476
Licenses & Permits	3,773
Annual Fees	75
Dues & Subscribtions	6,494
Alloc. From Managcare	572
Alloc. from Intercare	58
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,552

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,526
Alloc From ManagCare	699
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,225

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mayfield Care Center # 0029660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $8,447**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,670** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,644**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **31,000** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.